**U.S. Department of Labor**

Office of Administrative Law Judges
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**Issue Date: 27 July 2005**

CASE NO. 2004-BLA-6018

In the Matter of

JESSE C. WESTFALL,
Claimant

v.

UNION CARBIDE CORPORATION,
Employer

and

DIRECTOR, OFFICE OF WORKERS COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Larry L. Rowe, Esquire
For the Claimant

Mary Rich Maloy, Esquire
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

## DECISION AND ORDER-DENYING BENEFITS

This proceeding arises from a claim for benefits filed by Jesse C. Westfall, a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq.* Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on March 5, 2002 (DX 2), the new applications are applicable (DX 34).

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on January 11, 2005, in Charleston, West Virginia. At that time, all parties were afforded full opportunity present evidence and argument as provided in the Act and the regulations issued. Furthermore, the record was held open to allow Employer to submit the rereading of a chest x-ray which had initially been read by Dr. Patel (TR 20), and to allow Claimant to submit a rehabilitative report by Dr. Rasmussen (TR 28). The parties were initially given until March 21, 2005 to submit their respective briefs (TR 36).

On or about January 18, 2005, Claimant's counsel filed a "Motion to Submit Post Hearing Evidence," together with the transcript of Dr. Gaziano's deposition, dated December 9, 2004. In the absence of any objection, Dr. Gaziano's deposition has been marked and received as Claimant's Exhibit 6 (CX 6). Pursuant to leave granted at the formal hearing (TR 28), Dr. Rasmussen's post-hearing report, dated February 21, 2005, has been marked and received as Claimant's Exhibit 7 (CX 7). Pursuant to leave granted at the formal hearing (TR 20), Dr. Wheeler's rereading of the chest x-ray, dated June 28, 2004, has been marked and received as Employer's Exhibit 9 (EX 9).

In summary, the record consists of the hearing transcript, Director's Exhibits 1 through 34 (DX 1-34), Claimant's Exhibits 1 through 7 (CX 1-7), and Employer's Exhibits 1, 2, 5, 7, 8, and 9 (EX 1, 2, 5, 7, 8, 9). On the other hand, Employer's Exhibits 3, 4, and 6 have been excluded because these proffered exhibits exceed the evidentiary limitations set forth in the new regulations.[2]

Pursuant to my Order Granting Extension of Time, dated February 25, 2005, the deadline for the filing of the parties respective closing argument was extended to April 8, 2005. The closing arguments filed on behalf of Claimant and Employer, respectively, have been received and considered.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, testimony presented, and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

## Procedural History

On March 15, 1999, Claimant, Jesse C. Westfall, filed his initial application for black lung benefits under the Act, which was denied by the District Director's office on August 2, 1999. Claimant did not appeal nor take any further action within one year of the foregoing

[2] As stated above, Claimant's Exhibits 6 and 7 were submitted post-hearing. These exhibits should not be confused with the previously designated Claimant's Exhibits 6, 7, and 8, which were withdrawn at the formal hearing because they were duplicative of Director's Exhibits (TR 17-18).

decision. Accordingly, the above-referred claim is deemed finally denied and administratively closed (DX 1).

On March 5, 2002, Claimant filed the current application for black lung benefits under the Act (DX 2), which was denied by the District Director in a Proposed Decision and Order, dated on December 10, 2003 (DX 27). Following Claimant's timely request for a formal hearing (DX 30), this matter was referred to the Office of Administrative Law Judges for adjudication (DX 32-34). As previously stated, a formal hearing was held on January 11, 2005, and the record was closed following the receipt of the parties' closing arguments on April 8, 2005.

## Issues

I. Whether the claim was timely filed?
II. Whether the miner has pneumoconiosis as defined by the Act and the regulations?
III. Whether the miner's pneumoconiosis arose out of coal mine employment?
IV. Whether the miner is totally disabled?
V. Whether the miner's disability is due to pneumoconiosis?
VI. Whether the evidence establishes a material change in conditions per 20 C.F.R. §725.309.

(DX 32; TR 6-7).

Although the total disability issue was identified as a "contested" issue, Employer's counsel acknowledged: "I anticipate that you will find that the Claimant has a totally disabling pulmonary impairment, but I need for you to make the finding rather than me concede it." (TR 6).

## Findings of Fact and Conclusions of Law

### *I. Background*

A. Coal Miner and Length of Coal Mine Employment

On his initial application for benefits, Claimant alleged that he engaged in coal mine employment for 29 years ending in January 1984, when the mines shut down (DX 1). On the current application for benefits, Claimant reiterated that he stopped working as a coal miner in January 1984, when the mine shut down. However, Claimant alleged 32 years of work as a coal miner (DX 2). At the formal hearing, Claimant's counsel alleged 22.3 years of coal mine employment, as substantiated by the Social Security records (TR 7). This is consistent with the District Director's statement that Claimant had proven 22.3 years of coal mine employment (DX 27, Attachment; DX 32). Furthermore, Employer concedes that Claimant has established at least 16 years of coal mine employment (TR 6). Based upon the relevant evidence presented, particularly the Social Security records (DX 6), I find that Claimant has established at least 22 years of coal mine employment ending in 1984. Furthermore, I find that any discrepancy in the

exact number of years of coal mine employment in excess of 22 years is inconsequential for the purpose of rendering this decision.

B. Timeliness of Filing

Claimant filed the current, subsequent claim for benefits on March 5, 2002 (DX 2). Employer contends that this claim was not timely filed (DX 32; TR 6). Based upon the evidence presented, I find no merit in Employer's position. First, I note that there is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. §725.308(c). Secondly, the regulation states that the claim must be filed within three years after a medical determination of total disability due to pneumoconiosis "has been communicated to the miner or a person responsible for the care of the miner." Claimant testified that he was first told by a physician (*i.e.,* Dr. Rasmussen) that he suffered from black lung in 2003 (TR 33). Furthermore, there is no evidence that a physician expressly told him (or a person responsible for his care) that he is totally disabled by black lung. Accordingly, I find that Employer has failed to rebut the presumption of timeliness.

C. Responsible Operator

Employer, Union Carbide Corporation, is the properly designated responsible operator, under Subpart G, Part 725 of the regulations (DX 1, 2, 6; TR 30).

D. Personal, Employment, and Smoking History

Claimant was born in April 1937 (DX 1, 2).[3] As stated above, I find that Claimant engaged in coal mine employment for at least 22 years, ending in January 1984, when the mine closed down. On the "Description of Coal Mine Work and Other Employment" form, dated April 3, 2002, Claimant listed the Job Title of his last usual coal mine job as shuttle car operator. The job duties were as follows: "Haul coal from loader to Belt." The physical activities required for this job included 8 hours of sitting. Claimant reported "0" hours of standing, crawling, lifting and/or carrying (DX 5).[4]

After leaving the coal mines, Claimant worked for approximately 14 years in various non-coal mine related jobs, including construction, carpenter, carpenter helper, pipe layer, and work as a plumber's helper at a fiber optic plant (TR 30-31). Claimant's non-coal mine work entailed lifting and carrying (TR 31).

Claimant testified that he began smoking at age 21 or 22 (*i.e.,* 1958 or 1959). He stated that he continued smoking cigarettes until about two years ago, when he started smoking a pipe (TR 31-32).

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[3] There is a slight discrepancy in his exact birth date. On the initial application, Claimant listed his date of birth as "4-15-1937" (DX 1). On the current application, Claimant's birth date is listed as ""April – 17- 1937" (DX 2).

[4] As discussed herein, some of the medical reports describe Claimant's last usual coal mine job as entailing significantly more physical exertion than is set forth in the "Description of Coal Mine Work and Other Employment" form. However, as set forth below, the "total disability" issue is not determinative.

E. Dependents

Claimant has one dependent for the purpose of possible augmentation of benefits under the act; namely, his wife, Carolle Westfall (nee Hall). (DX 1, 2 , 8; TR 30).

F. State Award

Claimant testified that he filed a State black lung claim, while he was still working, and he received a 5% award (TR 34). However, the State statutes and regulations are not the same as those which govern this Federal claim. Furthermore, the relevant, probative medical evidence presented in this Federal claim significantly post-dates the State award. Therefore, I accord little weight to the State award.

*II. Medical Evidence*

As stated above, Claimant filed an initial claim on March 15, 1999, which was finally denied on August 2, 1999 (DX 1). Accordingly, there is a threshold issue as to whether Claimant has established a material change of condition under §725.309. However, the issue is muddled by the District Director's merger of the "total disability" and "causation" issues (DX 1). For the reasons outlined below, I find that the "subsequent claim" issue is inconsequential for the purpose of rendering this decision.

The medical evidence in the initial claim includes the following: interpretations of a chest x-ray, dated July 9, 1999, by Dr. Gaziano, a B-reader, and Dr. Navani, a B-reader and Board-certified radiologist, which are negative for pneumoconiosis; nonqualifying pulmonary function studies and arterial blood gas tests which were administered on August 28, 1979 and July 9, 1999; and, the medical reports of Drs. Rasmussen and Gaziano, dated August 28, 1979 and July 13, 1999, respectively (DX 1). In 1979, Dr. Rasmussen did not address the pneumoconiosis issue. However, at that time, Dr. Rasmussen opined that Claimant could perform "steady work at moderate to light work levels," and estimated Claimant's overall loss of functional capacity as 40% (DX 1). In 1999, Dr. Gaziano diagnosed chronic obstructive pulmonary disease and sinus bradycardia which he attributed to "non occupational" causes. In addition, Dr. Gaziano described the severity of Claimant's impairment as "moderate," and noted that Claimant is "not able to do former coal mine work." Furthermore, Dr. Gaziano stated that each of the diagnosed conditions (*i.e.,* chronic obstructive pulmonary disease and severe bradycardia) are disabling, unless the latter is correctable (DX 1).

In view of the progressive and irreversible nature of pneumoconiosis, I find that the above-referred medical data is less probative than the more recent evidence. This is particularly true of Dr. Rasmussen's initial report and the clinical data obtained in 1979, while Claimant was still engaged in coal mine employment. Furthermore, Drs. Rasmussen and Gaziano have conducted significantly more recent evaluations of Claimant, including clinical testing, and issued additional reports and/or testified at deposition in conjunction with the current claim. Accordingly, the primary focus herein is on the more recent chest x-rays, pulmonary function studies, arterial blood gases, and physicians' opinions, which were submitted in conjunction with the current claim, as summarized below.

A. Chest X-rays

The record contains various interpretations of recent chest x-rays, dated April 25, 2002 (DX 10, 11), July 15, 2003 (EX 1), August 20, 2003 (DX 11), and June 28, 2004 (CX 2; EX 9).

Some of the foregoing interpretations are limited to interpreting film quality and/or do not comply with the classification requirements set forth in §718.102(b). For example, Dr. Binns, a B-reader and Board-certified radiologist, only interpreted the April 25, 2002 x-ray for film quality, and reported "1" quality (*i.e.,* "Good"). (DX 10). Dr. Binns also provided the following descriptive x-ray reading of a film, dated July 15, 2003: "IMPRESSION: Emphysema. No active disease." (EX 1).

Of the remaining interpretations, only two are positive for pneumoconiosis under the classification requirements set forth in §718.102(b); namely, Dr. Gaziano's (1/0) reading of the April 25, 2002 film (DX 10); and, Dr. Patel's (1/0) interpretation of the chest x-ray, dated June 28, 2004 (CX 2). Drs. Gaziano and Patel are both B-readers. Furthermore, Dr. Patel is also a Board-certified radiologist.

On the other hand, there are four negative interpretations for pneumoconiosis, as follows: Dr. Wheeler's rereading of the April 25, 2002 x-ray (DX 11); the interpretations by Drs. Zaldivar and Wiot of the August 20, 2003 film (DX 11); and, Dr. Wheeler's rereading of the June 28, 2004 x-ray (EX 9). Drs. Wheeler, Zaldivar, and Wiot are all B-readers. Moreover, Drs. Wheeler and Wiot are also Board-certified radiologists.

In summary, the majority of the recent x-ray interpretations, including those by dual-qualified B-readers and Board-certified radiologists, are negative for pneumoconiosis. Accordingly, I find that Claimant has not established the presence of pneumoconiosis on the basis of the x-ray evidence.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

The record contains recent pulmonary function studies which were administered on April 25, 2002 (DX 10), August 20, 2003 (DX 1), June 28, 2004 (CX 4), and September 20, 2004 (EX 2), respectively.

None of the studies are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix B. Accordingly, the pulmonary function study evidence does not establish the presence of a totally disabling pulmonary or respiratory impairment.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The record includes recent arterial blood gas studies which were administered on April 25, 2002 (resting only) (DX 10), August 20, 2003 (resting and exercise)(DX 11), June 28, 2004 (resting and exercise)(CX 3), and September 20, 2004 (resting only)(EX 2).

Of the four recent *resting* blood gas studies, two are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix C (*i.e.,* the April 25, 2002 and June 28, 2004 results). Moreover, both of the recent *exercise* blood gas tests are qualifying. Taken as a whole, I find that the arterial blood gas evidence establishes the presence of a totally disabling pulmonary impairment.

D. Physicians' Opinions

The case file also contains miscellaneous medical records (EX 1), and the recent reports and/or deposition testimony of Drs. Gaziano (DX 10; CX 6), Zaldivar (DX 11; EX 5, 8), Rasmussen (DX 12; CX 1, 5, 7), and, Crisalli (EX 2, 7), respectively.

The miscellaneous medical records include: Dr. Robert C. Touchon's report of a Stress Cardolite Nuclear Study, dated June 5, 2002, with attached "Stress Data Sheet;" and, Dr. Scott E. Miller's correspondence, dated July 2, 2002 and September 19, 2003, respectively (EX 1). In summary, the "Stress Data Sheet" notes chest pain, dyspnea, fatigue, abnormal EKG, and a history of tobacco use. The findings on the Stress Cardiolite Nuclear Study were as follows: "1. Submaximal effort secondary to dyspnea. 2. Cardiolite shows fixed inferior wall defect without evidence of ischemia. 3. Left ventricular systolic function is preserved." (EX 1). On July 2, 2002, Dr. Miller stated that Claimant's "Adenosine Cardiolite showed no ischemia. There was some attenuation over the inferior wall on stress and rest but the echo showed no wall motion abnormality there." Dr. Miller also noted that Claimant's continued smoking puts him at risk for a sudden plaque rupture and a sudden MI (EX 1). On September 19, 2003, Dr. Miller stated, in pertinent part, that Claimant had stopped smoking cigarettes, but was smoking a pipe. Furthermore, lungs were "clear" on examination (EX 1).

Dr. Dominic J. Gaziano, a B-reader who is Board-certified in Internal Medicine, Chest Diseases, and Critical Care Medicine, examined Claimant on April 25, 2002 (DX 10).[5] On that date, Dr. Gaziano issued a letter to Claimant, which stated:

> During the course of your examination done in my office on 4/25/02 for the Department of Labor, your electrocardiogram was noted to be abnormal with sinus bradycardia, first degree heart block, and prolonged QT interval. I would recommend that you see your family physician as soon as possible and have further evaluation and I have enclosed a copy of your EKG for his reference.

[5] As stated above, Dr. Gaziano had initially examined Claimant in July 1999 (DX 1).

(DX 10). On a U.S. Department of Labor form, Dr. Gaziano reported that Claimant engaged in coal mine employment history for 32 years (29 underground), ending in January 1984. Dr. Gaziano apparently listed all of Claimant's coal mine jobs with Employer during the period from October 1968 to January 1984, instead of simply listing Claimant's last usual coal mine job, as requested. In addition, Dr. Gaziano noted the physical requirements of these jobs, as follows:

> timberman – walk, shovel coal, and lift timbers
> drill operator – sitting
> Beltman – Clean belts, walk
> Car dropper – walk
> Shuttle car operator – Sitting

( DX 10, Sec. B1a). Furthermore, Dr. Gaziano set forth Claimant's family, medical, and social histories. Dr. Gaziano noted that Claimant was currently smoking, and that he smoked 1 ½ packs per day beginning in 1957 (DX 10, Sec. C). In addition, Dr. Gaziano set forth Claimant's subjective complaints of sputum, wheezing, dyspnea, cough, chest pain, orthopnea, and paroxysmal nocturnal dyspnea (DX 10, Sec. D), as well as findings on physical examination (DX 10, Sec. D4). Dr. Gaziano did not summarize the results of clinical testing, as requested on the form report (DX 10, Sec. D5).

Under the Cardiopulmonary Diagnoses section of the U.S. Department of Labor form report, Dr. Gaziano stated:

> #1 Coal workers pneumoconiosis
> #2 Chronic bronchitis
> #3 Cardiac condition abnormal

(DX 10, Sec. D6). However, Dr. Gaziano failed to provide the bases for the stated diagnoses as requested on the form report (DX 10, Sec. D6). When asked the etiologies of the above-listed cardiopulmonary diagnoses, Dr. Gaziano attributed the coal worker's pneumoconiosis to coal mining, chronic bronchitis to tobacco use, and cardiac condition to "non occupational." However, Dr. Gaziano, again, failed to provide a rationale for his opinion (DX 10, Sec. D7). When asked the severity of Claimant's impairment and a rationale for his opinion, Dr. Gaziano simply noted: "not able to work in mines." (DX 10, Sec. D8a). When asked the extent to which each of the diagnosed conditions contributes to the impairment, Dr. Gaziano simply stated: "#1 & #2 unable to work in mines moderate abnormality. #3 disabled for moderate work." (DX 10, Sec. D8b).

On December 9, 2004, Dr. Gaziano testified at deposition (CX 6). Dr. Gaziano stated that he had examined Claimant on two occasions; namely, July 9, 1999 and April 25, 2002, respectively (CX 6, p. 5). On both occasions Dr. Gaziano found that Claimant suffered from a moderate pulmonary impairment which would preclude him from performing his usual occupation in the coal mines, but which may not be totally disabling from other occupations (CX 6, p. 6). Dr. Gaziano testified that he found x-ray evidence of pneumoconiosis in 1999 and 2002 (CX 6, p. 9). However, Dr. Gaziano's testimony is inconsistent with the actual medical records

which reveal that his x-ray reading in 1999 was negative for pneumoconiosis; and, only the 2002 reading was positive for pneumoconiosis (*See* DX 1). Although Dr. Gaziano attributed Claimant's impairment to a combination of smoking and coal dust exposure, he relied heavily upon positive x-ray evidence of pneumoconiosis, while also noting that his finding of rales on examination was consistent with pneumoconiosis, not cigarette smoking (CX 6, pp. 16-20, 30-31, 35). Furthermore, in 1999, when Dr. Gaziano found no x-ray evidence of pneumoconiosis, he attributed Claimant's disabling conditions (*i.e.,* chronic obstructive pulmonary disease and sinus bradycardia) to non-occupational factors (DX 1). Moreover, in 1999, Dr. Gaziano simply listed Claimant's last coal mine employment as "shuddle (sic) car operator." (DX 1, Sec. B). As stated above, the Description of Coal Mine Work and Other Employment form indicates that this was essentially a sedentary position, which entailed 8 hours of sitting (DX 5).

Dr. George L. Zaldivar is a B-reader, who is Board-certified in Pulmonary Disease, Internal Medicine, Sleep Disorder, and Critical Care Medicine (DX 11). Dr. Zaldivar examined Claimant on August 20, 2003. In a "History & Physical Examination" report on that date (DX 11), Dr. Zaldivar set forth Claimant's chief complaints of shortness of breath and irregular heart beat, as well as a history of present illness, past medical history, work history, personal and social history, family and personal illnesses, and, review of systems. Under "History of Present Illness," Dr Zaldivar reported that Claimant had stated that he has been short of breath for about 20 years. Claimant's past medical history included a 1 to 1 ½ pack per day cigarette smoking history which began "at about age 25 or 26" and ended "a year ago." Dr. Zaldivar also reported a 30-year coal mine employment history ending in 1983, when he was laid off. Thereafter, Claimant worked in construction until 1998. Regarding Claimant's last coal mine job, Dr. Zaldivar stated: "He [Claimant] says that for the last two years of work he was a shuttle car operator. It was low coal and he had to crawl into the car which was the hardest part of the job." In addition, Dr. Zaldivar also set forth his findings on physical examination. Regarding Dr. Zaldivar's examination of Claimant's lungs, Dr. Zaldivar stated: "Clear to auscultation. No wheezes, crackles or rales." In summary, Dr. Zaldivar stated:

**IMPRESSION:**

1. Yellow staining of the index finger of the right hand compatible with nicotine staining.
2. History of mine work.
3. History of shortness of breath.
4. History of emphysema.

(DX 11).

In a report, dated September 16, 2003 (DX 11), Dr. Zaldivar analyzed his own examination of Claimant, including laboratory data which he obtained, and he also reviewed other available evidence. In summary, Dr. Zaldivar stated:

**FINDINGS**

My own findings are as follows:

1. Summary of the History and Physical Examination as listed under "Impression."

2. No radiographic evidence of pneumoconiosis. There is evidence of healed fractured ribs on the right side.

3. High carboxyhemoglobin of a current smoker.

4. Moderate irreversible airway obstruction.

5. Mild air trapping by lung volumes.

6. Mild diffusion impairment.

7. Abnormal exercise test with exercise hypoxemia, which represents a moderate impairment for exercise.

**OPINIONS**

Taking all this information into consideration my answers to your (Employer counsel's) questions are as follows:

1. There is no evidence in this case to justify a diagnosis of coal worker's pneumoconiosis nor any dust disease of the lungs.

2. There is a pulmonary impairment present.

3. The pulmonary impairment is a result of Mr. Westfall's lifelong history of smoking, which has produced emphysema.

4. From the standpoint, according to (sic), on the description of his job as he gave it to me, he is capable of performing the work of a shuttle car operator. However, he would have difficulty performing the work of a driller and shooter, as he described it to me because of the necessity of carrying weight for a certain period of time. All of the impairment is a result of his smoking habit.

(DX 11).

In a supplemental report, dated December 7, 2004 (EX 5), Dr. Zaldivar reviewed various additional medical records, including a report by Dr. Rasmussen regarding his evaluation of Claimant on June 28, 2004, as well as clinical test results obtained on that date by Drs. Rasmussen and Patel. Following Dr. Zaldivar's analysis of the additional evidence and a discussion of medical literature, Dr. Zaldivar concluded:

1. There is no evidence in this case to justify a diagnosis of coal worker's pneumoconiosis nor any dust disease of the lungs.

2. A pulmonary impairment present.
3. The pulmonary impairment is a result of Mr. Westfall's lifelong history of smoking. This smoking habit has resulted in emphysema.
4. From the pulmonary standpoint, Mr. Westfall as of the time that he was examined by Dr. Rasmussen, was incapable of doing his usual coal mining work nor work requiring similar effort. All of the impairment is a result of his smoking habit which has caused very severe emphysema. Such emphysema was not related to his occupation. In fact, even if small coal macules were found by tissue biopsy, such macules would serve as a marker of his occupation and would have no bearing on the pulmonary function as reported, nor would I change my opinion as given regarding the cause of the pulmonary impairment or his ability to work for the reasons that I have given.

(EX 5). Thus, Dr. Zaldivar's opinion is essentially the same as expressed in his earlier report, dated September 16, 2003, except for his new finding that, as of the June 28, 2004 examination by Dr. Rasmussen, Claimant no longer retained the pulmonary capacity to perform his last usual coal mine job.

On December 27, 2004, Dr. Zaldivar testified at deposition (EX 8). In summary, Dr. Zaldivar reiterated that Claimant's pulmonary impairment is due to smoking, and that it is unrelated to pneumoconiosis and/or coal dust exposure. In so finding, Dr. Zaldivar discussed the nature of Claimant's impairment as shown on pulmonary function studies and arterial blood gas tests. Furthermore, he cited the x-ray evidence and medical literature (EX 8, pp. 16-18, 28, 31, 43-44, 62, 71-73). Dr. Zaldivar's testimony is somewhat equivocal regarding the total disability issue. Dr. Zaldivar stated Claimant could perform the primary job of a shuttle car operator once he crawled onto the machine, but that if he also had to help or perform general mining, Claimant would be disabled from such work (EX 8, pp. 34-35).

Dr. Donald L. Rasmussen is Board-certified in Internal Medicine and Forensic Medicine. Although he had training in pulmonary disease, he never took the qualifying examination for certification. However, Dr. Rasmussen testified that he has extensive experience evaluating people with lung disease for about 45 to 50 years (CX 5, pp. 4-5). Dr. Rasmussen, who had initially examined Claimant on August 28, 1979 (DX 1), issued a reviewing report, dated November 24, 2003 (DX 12), in which he analyzed Dr. Zaldivar's report, dated September 16, 2003. Based upon his review of Dr. Zaldivar's report, as well as citations to medical literature which Dr. Rasmussen authored or co-authored, Dr. Rasmussen opined that the pattern of impairment is "very typical for coal miners impaired as a consequence of coal mine dust induced lung disease or pneumoconiosis." Furthermore, Dr. Rasmussen opined that Claimant suffers from disabling chronic lung disease due to both cigarette smoking and coal mine dust exposure. Moreover, Dr. Rasmussen stated that Claimant's "coal mine dust exposure is a major contributing factor." (DX 12).

Dr. Rasmussen examined Claimant on June 28, 2004, and issued a report on that date (CX 1). Dr. Rasmussen set forth Claimant's subjective complaints, including shortness of breath with exertion for about 15 years. In addition, Dr. Rasmussen reported Claimant's past medical history, review of systems, habits, family history, occupational history, physical findings on

examination, and various clinical test results. Dr. Rasmussen noted a cigarette smoking history of about 1 pack per day beginning in 1953 and ending in 2002, when he started smoking a pipe. Dr. Rasmussen's reported description of Claimant's coal mine employment was as follows:

> The patient was employed in the coal mining industry between 1952 and 1983 for a total of about 23 years. He initially was a hand loader and he shot from the solid. He was a brakeman and coal drill operator, shuttle car operator. He worked on the belt line. Most of his work was at the face. His last job was that of shuttle car operator. He loaded and unloaded supplies. He cleaned at the tailpiece. He shoveled. He shoveled the belt. He rock dusted carrying 50# rock dust bags. Thus, he did considerable heavy and some very heavy manual labor.

(CX 1). The clinical test results included: a positive (1/0) x-ray reading by Dr. Patel; an abnormal electrocardiogram showing sinus bradycardia; ventilatory function studies revealing "minimal, reversible obstructive impairment;" a "moderately reduced" single breath carbon monoxide diffusing capacity; "moderate impairment" in oxygen transfer at rest; "marked impairment" in oxygen transfer with marked hypoxia on exercise. Based upon the foregoing, Dr. Rasmussen opined that Claimant "does not retain the pulmonary capacity to perform his last regular coal mine job." Furthermore, Dr. Rasmussen stated:

> The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude the patient has coalworkers' (sic) pneumoconiosis, which arose from his coal mine employment.
>
> The two risk factors for this patient's disabling lung disease are his cigarette smoking and his coal mine dust exposure. Both contribute. Both cause chronic obstructive lung disease including chronic bronchitis and emphysema.

(CX 1). After citing medical literature, Dr. Rasmussen concluded that Claimant's "coal mine dust exposure is a major contributing factor to his totally disabling chronic lung disease." (CX 1).

On December 9, 2004, Dr. Rasmussen testified at deposition (CX 5). In summary, Dr. Rasmussen discussed the available data and reiterated that the pattern of pulmonary or respiratory impairment is consistent with pneumoconiosis. Therefore, even if the x-ray evidence were negative for pneumoconiosis, this pattern indicates that coal mine dust is a significant contributing factor (CX 5, pp. 5-7, 10-21, 26-28, 32-33).

In a supplemental report, dated February 21, 2005, Dr. Rasmussen disagreed with the deposition testimony of Drs. Crisalli and Zaldivar, who had both found that Claimant does not have pneumoconiosis and/or a pulmonary impairment due to occupational exposure. Based upon his analysis, including citations to medical literature, Dr. Rasmussen reiterated that, in his opinion, Claimant "suffers a totally disabling respiratory insufficiency, which was due in significant part to his coal mine dust exposure." (CX 7).

Dr. Robert J. Crisalli, who is Board-certified in Internal Medicine and Pulmonary Diseases, examined Claimant on September 20, 2004 (EX 2). In the History and Physical report on that date, Dr. Crisalli set forth a 32-year coal mine employment history ending "around 1983," and Claimant's post-coal mine work. Dr. Crisalli reported Claimant's last usual coal mine employment was as a "belt man," where he had to "shovel coal."
In addition, Dr. Crisalli set forth Claimant's complaints of shortness of breath for 15 or more years and a cigarette smoking history of 1 to 1 ½ pack per day for 30 years ending two years ago, when he began smoking a pipe. Moreover, Dr, Crisalli reported Claimant's past medical history, family history, and, findings on physical examination (EX 2). In a supplemental report, dated November 4, 2004, Dr. Crisalli summarized his own findings and diagnoses, as follows:

1. Emphysema.
2. Chronic bronchitis.
3. History of irregular heart beat.

(EX 2). Furthermore, Dr. Crisalli reviewed and summarized other medical data, as well as clinical data which he obtained. Based upon the foregoing, Dr. Crisalli concluded:

> In summary, there is not sufficient objective evidence to justify a diagnosis of coal worker's pneumoconiosis or any chronic dust disease of the lung caused by or aggravated by coal mine employment in the case of Mr. Westfall. Mr. Westfall has tobacco smoking related pulmonary function impairment in the form of emphysema and chronic bronchitis. This impairment is of such degree that he would be unable to perform moderate degrees of work but may be able to perform periods of light work.

(EX 2).

On December 20, 2004, Dr. Crisalli testified at deposition (EX 7). Following a further discussion of Claimant's occupational and smoking histories and relevant medical evidence, Dr. Crisalli reiterated that Claimant suffers from a totally disabling pulmonary impairment due to smoking-induced emphysema, and which is unrelated to pneumoconiosis and/or coal mine dust exposure (EX 7, pp. 56-57, 93-95).

## Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. As stated above, the preponderance of the x-ray evidence, including the majority of the recent x-ray interpretations by dual-qualified B-readers and Board-certified radiologists, is negative for pneumoconiosis. Accordingly, I find that Claimant has not established the presence of pneumoconiosis under § 718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of §718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of §718.306 does not apply to cases in which the miner died after March 1, 1978. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis is defined in §718.201 means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.202(a)(1) and (2).

As outlined above, the record includes the recent medical opinions of Drs. Gaziano (DX 10; CX 6), Zaldivar (DX 11; EX 5, 8), Rasmussen (DX 12; CX 1, 5, 7), and, Crisalli (EX 2, 7), respectively.

In summary, Drs. Gaziano and Rasmussen both reported x-ray evidence of simple pneumoconiosis. Dr. Gaziano relied upon his own reading, while Dr. Rasmussen cited Dr. Patel's positive interpretation. Furthermore, as discussed above, Dr. Gaziano's diagnosis of pneumoconiosis and his conclusion that Claimant's impairment is due to a combination of smoking and coal dust exposure is primarily based upon his positive x-ray interpretation and his finding of rales on examination. However, as stated above, the preponderance of the x-ray evidence is negative for pneumoconiosis. Moreover, other physicians of record, including Dr. Rasmussen, did not report rales on more recent physical examinations. Since I find that the underlying bases for Dr. Gaziano's opinion is not credible, I accord his opinion little weight. Dr. Rasmussen stated that, even assuming that the x-ray evidence is negative for pneumoconiosis, he would still find that Claimant's coal mine dust exposure played a significant role in Claimant's pulmonary or respiratory impairment, because of the pattern of impairment. Therefore, even if Claimant did not establish "Clinical Pneumoconiosis," Dr. Rasmussen's opinion, if credited, would establish "Legal Pneumoconiosis," as defined in §718.201(a)(2). On the other hand, Drs. Zaldivar and Crisalli disagreed with Dr. Rasmussen's analysis regarding the etiology of Claimant's pulmonary or respiratory impairment. Based upon Claimant's history and the clinical test results, Drs. Zaldivar and Crisalli opined that the pattern of impairment is consistent with cigarette smoking, and that such impairment is *not* related to pneumoconiosis and/or coal mine dust exposure.

Having carefully weighed the conflicting evidence, I accord greater weight to the opinions of Drs. Zaldivar and Crisalli than those of Drs. Rasmussen and Gaziano. In making this determination, I find that the opinions of Drs. Zaldivar and Crisalli are more consistent with the credible, objective medical evidence, including the preponderance of the negative x-ray evidence, the reversibility cited on some of the pulmonary function tests, including the one administered by Dr. Rasmussen on June 28, 2004, and the fluctuating results on the resting arterial blood gas tests, which are inconsistent with the progressive and irreversible nature of pneumoconiosis. Furthermore, despite Dr. Rasmussen's extensive experience examining

patients with lung disease, he is not a Board-certified in Pulmonary Diseases. On the other hand, Drs. Zaldivar and Crisalli are both Board-certified pulmonary specialists. Although Dr. Gaziano is also Board-certified in Chest Diseases, his misplaced reliance on a positive chest x-ray and questionable physical finding of rales, undermines his opinion. In view of the foregoing, I find that Claimant has failed to establish pneumoconiosis under §718.202(a)(4), or by any other means.

I have also weighed all the relevant evidence together under 20 C.F.R. §718.202(a) to determine whether the miner suffered from pneumoconiosis. Since the weight of the x-ray evidence and medical opinion evidence fails to establish the presence of pneumoconiosis, I find that pneumoconiosis has not been established under 20 C.F.R. §718.202(a). *See, Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams,* 114 F. 3d 22 (3d Cir. 1997).

**Causal Relationship**

Since Claimant has not established the presence of (clinical or legal) pneumoconiosis, he also cannot establish that the disease arose from his coal mine employment. If Claimant had established the existence of pneumoconiosis, however, he would be entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. §718.203.

**Total Disability**

The regulations provide that a claimant can establish total disability by showing the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time. *See* 20 C.F.R. §718.204(b)(1). Where, as here, complicated pneumoconiosis is not established, total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* 20 C.F.R. §718.204(b)(2)(i)-(iv).

As outlined above, the pulmonary function evidence is not qualifying under the criteria set forth in Part 718, Appendix B. Therefore, Claimant has not established total disability pursuant to §718.204(b)(2)(i). On the other hand, the preponderance of the arterial blood gas evidence is qualifying under the regulatory standards set forth in Part 718, Appendix C. Therefore, Claimant has established total disability pursuant to §718.204(b)(2)(ii).

Since there is no evidence which establishes the presence of cor pulmonale with right-sided heart failure, Claimant has failed to establish total disability pursuant §718.204(b)(2)(iii).

As summarized above, the general consensus among the physicians of record is that Claimant's pulmonary or respiratory impairment would preclude him from performing his last usual coal mine job. Although there is some conflict and ambiguity regarding the exact nature of Claimant's last usual coal mine job, I find that, at the very least, Claimant had to crawl onto the shuttle car, since he was operating in low coal. Furthermore, various medical opinions suggest that Claimant also had to help with other manual work. Therefore, I find that Claimant has established total disability under §718.204(b)(2)(iv).

Having weighed all of the evidence, like and unlike, I find that, notwithstanding the nonqualifying pulmonary function studies, Claimant has established that he suffers from a totally disabling pulmonary or respiratory impairment based upon the arterial blood gases and medical opinion evidence.

## Total Disability Due to Pneumoconiosis

Since Claimant has failed to establish the presence of pneumoconiosis, even though a total (pulmonary or respiratory) disability has been found, he cannot establish total disability *due to pneumoconiosis* under §718.204(c). Moreover, for the reasons outlined above, I accord the most weight to the opinions of Drs. Zaldivar and Crisalli, who stated that Claimant's total disability is unrelated to pneumoconiosis and/or occupational dust exposure.

## Conclusion

Having considered the relevant evidence, I find that Claimant has not established the presence of (clinical or legal) pneumoconiosis and/or that his total (pulmonary or respiratory) disability is due to pneumoconiosis. Accordingly, Claimant is not eligible for benefits under the Act and regulations.

## ORDER

It is ordered that the claim of Jesse C. Westfall for benefits under the Black Lung Benefits Act is hereby **DENIED.**

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RICHARD A. MORGAN
Administrative Law Judge

**NOTICE OF APPEAL RIGHTS:** Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room B2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.